CENTERS FOR MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS	STRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	00	COMPLETED
	155605	D. WING		05/19/2011

NAME OF	PROVIDER OR SUPPLIER	l l	ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST	
GRAND	VIEW HEALTH & REHABILITATION CENTER		NSVILLE, IN46151	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000	This survey visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00089679 and IN00090001. Complaint IN00090001 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157 & F 272. Complaint IN00089679 - Unsubstantiated due to lack of evidence.	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forthon the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	
	Survey dates: May 15, 16, 17, 18, & 19, 2011. Facility number: 000400 Provider number: 155605 AIM number: 100266880			
	Survey team: Diane Dierks, RN-TC Marsha Smith, RN Patti Allen, BSW Leia Alley, RN			
	Census bed type: SNF: 12 SNF/NF: 59 Total: 71			
	Census payor type: Medicare: 19			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
7 HVD TE/HV	of condection	155605	A. BUILDING	00	05/19/2011
			B. WING STREET.	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER			COLUMBUS ST	
GRAND\	VIEW HEALTH & RE	EHABILITATION CENTER	MARTI	NSVILLE, IN46151	
(X4) ID	1	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE
	Medicaid: 46				
	Other: 6				
	Total: 71				
	Sample: 15				
	Supplemental sar	mple: l			
	These deficiencie	es reflect state finding			
		ice with 410 IAC 16.2.			
		ompleted on May 25,			
	2011 by Bev Fau	lkner, RN			

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED		
		155605	B. WING		05/19/2011
	PROVIDER OR SUPPLIER	HABILITATION CENTER	1959 E	ADDRESS, CITY, STATE, ZIP CODE E COLUMBUS ST INSVILLE, IN46151	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F0157 SS=D	A facility must immoresident; consult wand if known, notifice representative or a when there is an a resident which respondential for requiring significant change mental, or psychosocial statuconditions or clinical alter treatment significant in the psychosocial statuconditions or clinical terteatment significant in a discontinue an exist to adverse consequence form of treatment facility as specified. The facility must at resident and, if known representative or in when there is a change in reside state law or regular paragraph (b)(1) of the facility must resident's legal registerity in the second reversident's legal registerity facility facil	nediately inform the with the resident's physician; by the resident's legal an interested family member accident involving the ults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or is in either life threatening and complications); a need to inficantly (i.e., a need to sting form of treatment due puences, or to commence a ment); or a decision to ge the resident from the drin §483.12(a). Iso promptly notify the bown, the resident's legal interested family member ange in room or roommate accified in §483.15(e)(2); or ant rights under Federal or actions as specified in of this section. The cord and periodically is and phone number of the presentative or interested intere	F0157	1. Resident A's physician wanotified and the resident was admitted to the hospital for treatment of an acute conditionand has since returned.2. Al residents have the potential affected. See below for corrective measures.3. Licentursing staff were re-educated.	as 06/06/2011 on I to be insed
	was report			policy related to physician	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPLE 05/19/20	ETED	
	PROVIDER OR SUPPLIER		B. WIN	1959 E	ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST NSVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	(X5) COMPLETION DATE
	physician manner for residents is significant sample of A). Findings if A facility January, 2 "Acute Che Condition	in a timely or 1 of 8 reviewed for t changes in a 15. (Resident noluded: policy, dated 2006, and titled nange in /Emergency			CROSS-REFERENCED TO THE APPROPRIA	des in), d and The view ur ly on iitely on the gs of luring / e plan ly.5. ures	
	the Direct (DON) on 12:15 p.m	e," provided by or of Nursing 5/17/11 at, included, but mited to, the					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	(X2) MU A. BUIL		NSTRUCTION 00		DATE SURVEY COMPLETED 5/19/2011
		100000	B. WING		DDRESS, CITY, STATE, Z	_	JI 1812U I I
NAME OF I	PROVIDER OR SUPPLIER	₹			COLUMBUS ST	III CODE	
GRAND\	/IEW HEALTH & RE	EHABILITATION CENTER		MARTIN	ISVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	"Purpos	e: To ensure an					
	acute char	nge in a					
	resident's	condition will					
	be address	sed in a timely					
	manner as						
	needed transfer to an						
	acute care						
	Contact th	ne attending					
	physician	on-call					
	physician	when the					
	resident's	condition					
	requires in	mmediate					
	attention	or acute care					
	follow-up) <mark>''</mark>					
	A facility	policy, dated					
		2006, and titled					
		n & Family					
		on Procedure,"					
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	DHOM11	Facility I	D: 000400 I	f continuation sheet	Page 5 of 57

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL	LETED
	PROVIDER OR SUPPLIER	HABILITATION CENTER	p. winc	STREET A	COLUMBUS ST NSVILLE, IN46151	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	provided t	the DON on					
	5/17/11 at	12:15 p.m.,					
	included,	but was not					
	limited to	the following:					
	for all emocondition require an response physician in condition may not we change in plan" The clinic Resident A	ergencies or all changes that immediate .2. Notify the of any change on that may or varrant a the treatment al record for A was reviewed					
	on 5/16/11	1 at 2:00 p.m.					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	(X2) MULTIPI A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE COMPL 05/19/2	LETED
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STR 195	59 E	ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST NSVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Diagnoses	s for Resident					
	A include	d, but were not					
	limited to	, small bowel					
	obstructio	n, small bowel					
	resection	(surgical					
	procedure), history of						
	gastrointe	stinal bleed,					
	gastroesoj	phageal reflux					
	disease, co	onstipation,					
	gallstones	, anemia,					
	dementia,	psychosis,					
	anxiety ar	nd depression.					
	Nursing 1	notes included,					
	but were i	not limited to,					
	the follow	ring:					
	4/20/11 at	2:00 p.m.: sident)					

	OF OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	A. BUII	LDING	NSTRUCTION 00		3) DATE SURVEY COMPLETED 05/19/2011
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE,	ZIP CODE	
		EHABILITATION CENTER	-	L	ISVILLE, IN46151		(7/5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIES	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
	nauseous	and vomiting					
	all shift'	"					
	4/20/11 at	: 11:30 p.m.:					
	"nurse r	eported that res					
	has vomit	ed 3-4					
	x's(times)	this evening"					
	4/21/11 at 5:00 a.m.:						
	"Res has vomited x 2,						
	vomit is d	lark					
	green/blac	ck, with odor					
	similar to	stoolmorning					
	meds held	l secondary to					
	vomiting.	"					
	4/21/11 at	: 12:00 p.m.:					
	"residen	nt vomited at 9					
	a.m. after						
	breakfast.	resident given					
	enema &	results of x					
	lg(extra la	arge)					
	MD(me	dical doctor)					
FORM CMS-2	L 2567(02-99) Previous Version	ons Obsolete Event ID:	DHOM11	Facility I	D: 000400	If continuation shee	t Page 8 of 57

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE COMPI 05/19/2	LETED
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	05/19/2	:011
	PROVIDER OR SUPPLIER			1959 E	COLUMBUS ST		
(X4) ID		TATEMENT OF DEFICIENCIES	<u> </u>	ID I	NSVILLE, IN46151		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	Е	COMPLETION DATE
	called and	is aware of					
	condition.						
	During an	interview on					
	5/17/11 at	11:50 a.m.,					
	the DON indicated the						
	nurse on night shift (RN						
	# 5) who a	assessed the					
	vomiting	as dark					
	green/blac	ck, with odor					
	similar to	stool (4/21/11					
	at 5:00 a.r	n.), did not					
	notify the	physician at					
	the time o	f the					
	occurrenc	e. She					
	indicated	the physician					
	was not no	otified until the					
	next shift	(4/21/11 at					
	12:00 p.m	and no					
	orders we	re received at					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	(X2) MULTIPLE (A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/19/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	1959	CADDRESS, CITY, STATE, ZIP C E COLUMBUS ST CINSVILLE, IN46151	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	that time.	After the					
	interview,	, the DON					
	provided a	a time line,					
	which ind	icated the					
	exact time	e of initial					
	physician	notification					
	was 4/21	/11 at 10:00					
	a.m and was done by						
	LPN # 1.						
	During an	interview with					
	LPN # 1 c	on 5/19/11 at					
	10:56 a.m	., she indicated					
	after the n	ight shift had					
	reported to	o her that					
	Resident A	A had vomited					
	during the	e night, she					
	notified th	ne physician on					
	4/21/11 at	10:00 a.m.					
	and no ord	ders were					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/19/2	LETED
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	D. WIIV	1959 E	ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST NSVILLE, IN46151	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	received.	She indicated					
	she inforn	ned the					
	physician	Resident A had					
	vomited tl	hroughout the					
	night with	small bowel					
	movemen	ts noted. She					
	indicated she did not						
	remember if she reported						
	to the phy	sician that the					
	vomit was	s dark green					
	with the s	mell of stool,					
	because sl	he was not sure					
	if the nigh	nt shift had					
	reported the	his description					
	to her.						
	This Fede	ral tag is					
	related to	complaint					
	IN000900	01.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/19/2011	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	STREET A 1959 E	COLUMBUS ST NSVILLE, IN46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F0272	3.1-5(a)(2	onduct initially and			
SS=D	periodically a comp standardized repro- each resident's fur. A facility must make assessment of a re- RAI specified by the must include at lead Identification and of Customary routine Cognitive patterns Communication; Vision; Mood and behavion Psychosocial well- Physical functioning Continence; Disease diagnosist Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentian Documentation of regarding the additional performed through protocols; and Documentation of	prehensive, accurate, aducible assessment of actional capacity. The accomprehensive desident's needs, using the action of actional capacity. The assessment desident's needs, using the action of	E0272	1 Resident A returned from	the 06/06/2011
	Based on intervie facility failed to	ew and record review, the ensure a small bowel esulted in hospitalization	F0272	 Resident A returned from hospital to the facility and is currently stable.2. All reside have the potential to be affect 	nts

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155605	B. WING			05/19/2	011
	PROVIDER OR SUPPLIER	HABILITATION CENTER		1959 E (DDRESS, CITY, STATE, ZIP CODE COLUMBUS ST ISVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION DATE
	and surgical interappropriately assisted reviewed for sign sample of 15 (Reference Findings include A facility policy, and titled "Nursis Policy and Proced Director of Nursis 5:42 p.m., include to, the following "Purpose: To a organized manner information relating nurses' notesfor occurrenceeach hoursAny conconditionnot list to:Bowelasset A facility policy, titled "Bowel Soprovided by the Inp.m. included, but following: "Bowel sounds licensed professi	rvention was essed for 1 of 8 residents nificant changes in a esident A). d: revised March, 2011, ng Department Charting dure," provided by the ing (DON) on 5/17/11 at ed, but was not limited : ccurately document in an er all pertinent ed to the resident in the fllow-up of a shift X(times) 24 lition nental assessments will be significant changes in mited			See below for corrective measures.3. The Nursing Charting Policy and Procedul was reviewed, along with the Bowel Assessment policy (suttachments C and D), and changes were indicated. Licensed nursing staff were re-educated on both policies. The DON or her designee were ivew Nurse's Notes and the 24-Hour Condition Reports on scheduled work days indefinitely to ensure change condition are assessed and documented on accordingly resolved (see attachment B). The findings of these audits be reviewed during the facility quarterly Quality Assurance meetings and the plan of accordingly.5. The above corrective measures completed on or before June 2011.	e ee ee no s	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE COMPI		
		155605	B. WIN			05/19/2	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	COLUMBUS ST		
GRAND\	/IEW HEALTH & RE	HABILITATION CENTER		MARTIN	NSVILLE, IN46151		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
IAG	physician's order	LSC IDENTIFYING INFORMATION)		IAG	BEIGER(1)		DATE
	1 * *	•					
	pertinent observations in the medical record"						
	The clinical reco	rd for Resident A was					
	reviewed on 5/16						
	10,10,000 011 3,10	,, 11 at 2 .00 p.m.					
	Diagnoses for Re	esident A included, but					
	were not limited	,					
		ll bowel resection					
	(surgical procedu						
		oleed, gastroesophageal					
	reflux disease, co	onstipation, gallstones,					
	anemia, dementia	a, psychosis, anxiety and					
	depression.						
	Mayo Clinic.com	n's web site included, but					
	was not limited t	· · · · · · · · · · · · · · · · · · ·					
		stinal obstruction:					
	"Intestinal obst	ruction is a blockage of					
		caused by many					
	l '	ding fibrous bands of					
	tissue in the abdo						
	l ` ′	estinal obstruction can					
		ninal pain and swelling,					
	nausea, and vom	_					
		ause the blocked parts of					
		can lead to perforation					
	· ·	evere infection and					
	shockif left unt						
	obstruction can c						
	_	complications, including:					
	death of the affect	eted intestinetissue					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE : COMPL		
		155605	B. WIN			05/19/2	011
	PROVIDER OR SUPPLIER	HABILITATION CENTER		1959 E	ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST NSVILLE, IN46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	VTE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	A1E	DATE
	death can result i	n a tear					
	(perforation)wl	hich can lead to					
	infection Perito	onitis is the medical term					
	for infection in the	ne abdominal cavitya					
	life-threatening c	condition that requires					
	immediate medic	cal and surgical					
	attention"						
	•	sheet, with an original					
		nd a goal date of 5/9/11,					
		nt A was at risk for :					
		ting, gastric distention,					
		ng. Interventions					
		r for signs and symptoms					
		ausea and vomiting, and					
		tion and report abnormal					
	findings to the pl	nysician as needed					
	Nurging notes in	cluded, but were not					
	limited to, the following						
ı	ininica to, the io.	nowing.					
	4/20/11 at 2:00 p	.m.: "Res(resident)					
	nauseous and voi	miting all shift"					
		p.m.: "nurse reported					
	that res has vomi	ted 3-4 x's(times) this					
	evening"						
	4/21/11 at 5:00 a	.m.: "Res has vomited					
	x 2, vomit is darl	green/black, with odor					
	similar to stool	morning meds held					
	secondary to von	niting"					
	4/21/11 at 12:00 p.m.: "resident vomited						
	at 9 a.m. after breakfastresident given						
	enema & results	of x lg (extra large)					
	MD (medical d	loctor) called and is					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMP	SURVEY LETED	
		155605	A. BUII B. WIN			05/19/2	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	p. with	STREET A	DDRESS, CITY, STATE, ZIP CODE COLUMBUS ST ISVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	aware of condition 4/22/11 at 10:00 shiftPo (by mo to) vomiting" 4/23/11 at 12:40 (large) amount of similar to BM (by sounds faint slugger call MD paged 4/23/11 at 1 a.m. from on-call physic for KUB (kidney and IM (intramusing every 6 hours 4/23/11 at 1:20 at company) contacts soon as possible 4/23/11 at 7:00 at called to MD, also info [sic] of resident to ER [experience of ambulance contransport" 4/23/11 at 12:00 at admitted to [name of the contral cont	p.m.: "Emesis x 1 this uth) meds held d/t (due a.m.: "Vomited lrg f green emesis with odor owel movement). Bowel gish, abdomen firmOn " : "Received call back sician. N.O. (new order) r, ureter, bladder x-ray) scular) Phenergan 12.5 s prn (as needed)m.: "(name of eted to order STAT (as to KUB order" .m.: "KUB results so contacted MD with lent cont [continuing] to od pressure) 72/40, eived orders to send mergency room][name mpany] here to p.m.: "resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		155605	B. WIN			05/19/20)11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
				1	COLUMBUS ST		
GRANDV	/IEW HEALTH & RE	EHABILITATION CENTER		MARIII	NSVILLE, IN46151		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	off and on vomiting x (times) 48 hrs (hours)KUB (x-ray of kidneys, ureter,						
	` ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′						
	and bladder) don	e 4/23"					
	**	1 . 15/5 15/6/11					
	•	, dated 5/5 and 5/6/11,					
		nt A was then transferred					
		ng hospital to another					
	_	11 for a small bowel					
		underwent surgery on					
	· ·	esulted in a resection of					
	the small bowel.						
	_	dicated the onset of					
	_	ymptoms of nausea and					
	_	cumented on 4/20/11 at					
	•	were no entries from					
		p.m. until 4/22/11 at					
	-	eating a 34 hour time span					
		ent of the change in					
		tatus. There was also no					
		wel sounds until 4/23/11					
	at 1:20 a.m.						
	_	iew with the DON and					
		17/11 at 11:50 a.m., the					
	•	Resident A were					
		er the DON or ADON					
	provided an expl	anation for the lack of					
	assessment of the	e change in					
	gastrointestinal s	tatus.					
	This Federal tag	is related to complaint					
	IN00090001.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155605	A. BUILDING B. WING		05/19/2011
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	
GRANDV	/IEW HEALTH & RE	HABILITATION CENTER		9 E COLUMBUS ST RTINSVILLE, IN46151	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	3.1-31(a)				
F0282	The services provi	ded or arranged by the			
SS=D	facility must be pro in accordance with plan of care.	ovided by qualified persons a each resident's written observation,	F0282	1. Residents #33, 36 and 43	
		and record		were not harmed. Care plar related to pain management reviewed and revised as	
		he facility		needed.2. All residents with potential for or actual pain ha	
		ensure care		the potential to be affected plans of care related to pain	All have
				been reviewed and revised a indicated.3. The policies relationship	
	_	l physicians		to pain management and medication administration	on
orders were followed				(see attachments E and F) w	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		ONSTRUCTION 00	(X3) DATE S COMPL		
		155605	A. BUI B. WIN	LDING IG		05/19/2	
NAME OF I	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE		
GRAND\	/IEW HEALTH & RE	HABILITATION CENTER		1	COLUMBUS ST NSVILLE, IN46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	COMPLETION
IAG	as written for 3 of 15			TAG	reviewed and no changes w indicated. Licensed nursing		DATE
	residents	reviewed for		were re-educated on those policies. The DON or her designee will review narcotic	,		
		on orders and			records, medication administration records and F	PRN	
	_	s in a sample			Medication Flowsheets (which include assessments) daily of the last transfer of the last tran		
	of 15 (R	esidents # 33,			scheduled work days (see attachment G) for one month twice weekly for one month,		
	# 36, and	. # 43).					
	Findings	included:			continued compliance. Pain plans will be reviewed by the DON or her designee month three months then quarterly thereafter (see attachment F The findings of these audits be reviewed during the facili		
	1. The re	ecord for			quarterly Quality Assurance meetings and the plan of action		
	Resident	# 33 was			adjusted accordingly.5. The above corrective measures of completed on or before,	will be	
	reviewed	on 5/18/11 at			,		
	1:30 p.m.	•					
	Diagnosc	os included					
		es included					
	but are no	ot limited to,					
	CHF, anxiety, angina (chest pain), gall						
	stones, no	europathy					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/19/2011		
		155005	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	05/19/2011	
NAME OF I	PROVIDER OR SUPPLIEF	R		1959 E	COLUMBUS ST		
GRAND\	/IEW HEALTH & RE	EHABILITATION CENTER		MARTIN	NSVILLE, IN46151		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	CON	(X5) MPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	DATE
	(nerve pa	ain) coronary					
	artery dis	sease,					
	osteopor	osis, and					
	emphyse	ma.					
	A recapit	tulated					
	physiciai	ns order for					
	the mont	hs of April					
	and May	, indicated					
	Resident	#33 had an					
	order for						
	Hydroco	done-APAP					
	10-500 n	ng, 1 tablet by					
	mouth ev	ery 8 hours					
	PRN (as	needed) for					
	pain.						
	A care pl	an for pain,					
	initiated	4/8/11 and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		R: [2) MULTIPLE CO BUILDING	NSTRUCTION 00		B) DATE SURVEY COMPLETED	
		155605	В.	WING			05/19/2011
NAME OF I	PROVIDER OR SUPPLIEF	₹		I	ADDRESS, CITY, STA		
GRAND\	/IEW HEALTH & RE	EHABILITATION CENT	ER	I	NSVILLE, IN461		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENC ICY MUST BE PERCEDED B LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	LAN OF CORRECTION TE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
	updated 4	4/26/11,					
	indicated	l Resident #	<i>‡</i>				
	33 had the potential						
	for pain i	in the					
	following	g areas: ch	est,				
	general,	Rt (right)					
	foot, and	back. The	e				
	goal for	Resident # :	33				
	was a pa	in score of	5				
	or less or	n a scale of					
	0-10. A1	n interventi	on				
	list relate	ed to proble	ms				
	indicated	I the facility	7				
	would ac	lminister pa	ain				
	medication	ons as orde	red				
	and mon	itor efficac	y.				
	During re	eview of th	e				
	facility's	Narcotic					
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete I	Event ID: DHO	M11 Facility	ID: 000400	If continuation sheet	Page 21 of 57

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE: COMPL 05/19/2	ETED	
	PROVIDER OR SUPPLIER	IL R EHABILITATION CENTER		1959 E	DDRESS, CITY, STATE, ZIP CODE COLUMBUS ST ISVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Control I	Record,					
	Resident	# 33 received					
	PRN pair	n medication					
	on May 5	5th and May					
	8th at 6 a	ı.m. and 12:00					
	"N" (indi	icating Noon					
	hour). T	he record					
	indicated	l only 6 hours					
	between	doses.					
	Resident	# 33 received					
	PRN pair	n medication					
	on May	10th at 7:00					
	a.m. and	12 "N". The					
	record in	dicated only 5					
	hours bet	tween doses.					
	Resident	#33 received					
	PRN pair	n medication					
	on May 1	13th at 5:00					
	a.m. and	10:00 a.m.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		ĺ	IULTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPI		
		155605	B. WIN	NG		05/19/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST		
GRAND\	/IEW HEALTH & RE	HABILITATION CENTER		1	NSVILLE, IN46151		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE
	The reco	rd indicated					
	only 5 ho	ours between					
	doses. F	Resident #33					
	received	PRN pain					
	medication	on on May					
	15th at 12	2 "N" and					
	2:00 p.m	. The record					
	indicated	only 2 hours					
	between	doses.					
	During a	n interview					
	with the	Director of					
	Nursing ((DON) on					
	5/19/11 a	at 3:30 p.m.,					
	further in	formation					
	was requ	ested in					
	regards to	0					
	the medic	cation being					
	administe	ered before					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605		ULTIPLE CO LDING	NSTRUCTION 00	COM	TE SURVEY MPLETED 9/2011
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CO		5/2011
GRAND\	/IEW HEALTH & RE	EHABILITATION CENTER		1	COLUMBUS ST NSVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	the order	suggested it					
	could be	administered.					
	The DON	N indicated					
	that there	e was no other					
	informati	ion available.					
	During re	eview of the					
	facility's	Narcotic					
	Control F	Record,					
	Resident	# 33 received					
	PRN pair	n medication					
	every day	y in the month					
	of April,	except April					
	4th, 2011	. A review of					
	Resident	#33's "prn					
	pain man	agement flow					
	sheet" for	r April,					
	indicated	Resident #33					
	received	an assessment					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CO	NSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155605	IDEK:	A. BUIL		00		05/19/2	
		1.00000		B. WINC	_	DDDEGG CITY GT 1	TE ZID CODE	00/10/2	···
NAME OF P	PROVIDER OR SUPPLIER					DDRESS, CITY, STAT	*		
GRANDV	/IEW HEALTH & RE	HABILITATION CE	NTER			NSVILLE, IN4615			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIE	ENCIES	\dashv	ID I	·			(X5)
PREFIX		CY MUST BE PERCEDE		1	PREFIX	(EACH CORRECTIVE	.AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT	-	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)				TAG		CIENCY)		DATE
	of pain 1	evels, nee	ed of						
	medication, alternative								
	and non								
	pharmacological								
	methods,	and effic	acy						
	on the fo	llowing d	ates:						
	April, 13th 15th, 19th,								
	21st, 23rd	d, 24th, 20	6th,						
	27th, 28t	h, and 291	th,						
	2011. Th	e record							
	indicated	18 days	of						
	PRN pair	n medicat	ion						
	was adm	inistered							
	without p	orior							
	*	nt of pain	l .						
		1							
	During re	eview of t	he						
	facility's	Narcotic							
	Control F	Record,							
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete	Event ID:	DHOM11	Facility I	D: 000400	If continuation sh	neet Pa	ge 25 of 57

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE COMPL	
155605		155605	B. WIN	IG		05/19/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST		
GRANDV	/IEW HEALTH & RE	HABILITATION CENTER		MARTIN	NSVILLE, IN46151		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		# 33 received					
	the PRN pain						
	medication	on each day,					
	from Ma	y 1st to May					
	17th. A 1	review of					
	Resident	#33's "prn					
	pain man	agement flow					
	sheet" for	r May,					
	indicated	Resident #33					
	received	an assessment					
	of pain l	evel, need of					
	medication	on, alternative					
	and non						
	pharmaco	ological					
	methods,	and efficacy					
	on the fol	llowing dates:					
	May, 2nd	l, 3rd, 5th,					
	6th, 7th,	8th, 10th,					
	15th, 16t	h and 17th,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605			(X2) MULTIPI A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIEF	EHABILITATION CENTER	STR 198	59 E	ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST NSVILLE, IN46151	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	2011. T	he record					
	indicated	l 7 days of					
	PRN pair	n medication					
	was adm	inistered					
	without p	orior					
	assessme	ent of pain.					
	During a	n interview					
	with the	DON on					
	5/19/11 a	at 2:00 p.m.,					
	further in	nformation					
	was requ	ested in					
	regards to	0					
	assessme	ents. No					
	further in	nformation					
	was avai	lable.					
	2. The re	ecord for					
	Resident	# 36 was					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 1/2011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET. 1959 E	ADDRESS, CITY, STATE, ZIP C COLUMBUS ST NSVILLE, IN46151	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	reviewed	on 5/18/11 at				
	1:00 p.m	•				
	are not li coronary disease, o osteopore Myasther angina (c constipat	artery chronic pain, osis, nia Gravis, chest pain),				
	the mont and May	ns order for hs of April , indicated dent # 36 had				

AND PLAN OF CORRECTION IDENT		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	A. BUI	LDING	ONSTRUCTION 00	(X3) DATE COMPI 05/19/2	ETED
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/13/2	.011
	PROVIDER OR SUPPLIER			1	COLUMBUS ST		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	NSVILLE, IN46151		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		ATE	COMPLETION
TAG	_	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	_	done-APAP					
	7.5-500 mg, liquid						
	suspension, give 10 ml						
	by mouth	ever 6 hours					
	PRN (as	needed) for					
	pain.						
	A care pl	an for pain,					
	initiated 4	4/8/11 and					
	updated 4	4/20/11,					
	indicated	Resident #					
	36 had tl	he potential					
	for pain i	n the					
	following	g areas:					
	generaliz	ed, chest and					
	stomach.	The goal for					
	Resident	# 36 was a					
	pain scor	e of 5 or less					
	on a scale	e of 0-10. An					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	ONSTRUCTION 00	COMPL	ETED
		155605	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	05/19/2	011
NAME OF F	PROVIDER OR SUPPLIER			1959 E	COLUMBUS ST		
		HABILITATION CENTER		<u> </u>	NSVILLE, IN46151		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPI		ATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	112	DATE
	intervention list						
	related to problems						
	indicated	the facility					
	woulda	administer					
	pain med	ications as					
	ordered a	and monitor					
	efficacy.						
	During re	eview of the					
	facility's	Narcotic					
	Control F	Record,					
	Resident	# 36 received					
	PRN pair	n medication					
	on April	2nd, 19th,					
	20th and	21st, 2011.					
	A review	of Resident #					
	36's "prn	pain					
	managen	nent flow					
	sheet" for	r April,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	A. BUII	LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/19/2	ETED
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE	00/10/2	
GRAND\	/IEW HEALTH & RE	HABILITATION CENTER			NSVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	indicated	Resident #36					
	received an assessment						
	of pain level, need of						
	medication	on, alternative					
	and non						
	pharmaco	ological					
	methods,	and efficacy					
	on the fo	llowing dates:					
	April 20t	h and 21st.					
	The reco	rd indicated 2					
	days of 1	PRN pain					
	medication	on was					
	administe	ered without					
	prior asse	essment of					
	pain.						
	During re	eview of the					
	facility's	Narcotic					
	Control F	Record,					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605		LDING	NSTRUCTION 00		E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER	HABILITATION CENTER	p. wiiv	1959 E	DDRESS, CITY, STATE, ZIP CODE COLUMBUS ST ISVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	Resident	# 36 received					
	PRN pain medication						
	on May 2	2nd, 7th, 11th					
	and 12th,	, 2011. A					
	review of	f Resident #					
	36's "prn	pain					
	managen	nent flow					
	sheet" for	r May,					
	indicated	Resident #					
	36 receiv	ved no					
	assessme	nt of pain					
	level, nee	ed of					
	medication	on, alternative					
	and non						
	pharmaco	ological					
	methods,	and efficacy.					
	The docu	ment was					
	blank. 3. The record of	Resident # 43 was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUF	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPLET	ED
		155605	B. WIN			05/19/201	1
			p. ,,,,,		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				COLUMBUS ST		
GRANDV	/IEW HEALTH & RE	HABILITATION CENTER			NSVILLE, IN46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed on 5/18	3/11 at 1:15 p.m.	İ			İ	
	Diagnoses for Re	esident # 43 included, but					
	_	to, neurofibromatosis,					
		mors along nerves)					
	` •	,					
	_	ropathy and major					
	depressive disord	ier.					
	Recapitulated ph	ysician's orders for					
	1 ^ ^	the resident could					
	receive Percocet (a narcotic pain medication) 5-325 milligrams- 1 tablet						
	l -	needed for pain. The					
	original date of the	his order was 11/12/10.					
	A care plan for R	esident # 43, dated					
		d a problem of "The					
	· ·	ootential for pain in the					
	_	general, pelvic Due to:					
	· -	Neurofibromatosis, Large					
		conic pain, Neuropathy."					
	_	esident would have a pain					
	less than 5 on a s						
		luded, but were not					
		s pain on a scale of 0 -					
	1	er interventions such as:					
	massage, repositi	oning, Administer pain					
	medications as or	rdered and monitor					
	efficacy"						
	D. L. C. DDA	IM. E. Cl. (
		Medication Flow Sheets					
		is to be filled out for date,					
	_	n severity, attempted					
	alternative interv	entions, medication,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION 155605		IDENTIFICATION NUMBER:	A. BUII	LDING	00			
		155605	B. WIN			05/19/2	JII	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
GRANDV	/IEW HEALTH & RE	EHABILITATION CENTER		1	COLUMBUS ST NSVILLE, IN46151			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	IAG	DEFICIENCY)		DATE	
	initials and effectiveness each time a PRN pain medication was given.							
	Review of Controlled Drug Record sign							
		ted Resident # 43						
		cet 96 times in April,						
	2011.	oot 70 miles in April,						
	2011.							
	A review of Res	ident # 43's PRN						
		Sheets indicated only 38						
		assessment of his pain						
	-	s of the administered pain						
		of the 96 times it was						
	given in April.							
	During an intervi	iew with the Regional						
	Nurse Consultan	t on 5/19/11 at 4:15 p.m.,						
		resident's pain is						
		ssessed every time a PRN						
	l *	is administered, and the						
		pposed to be put on the						
		Flow Sheet, along with						
	1 ^	essment regarding the						
		the drug. She indicated						
		process is part of the						
	resident's care pl	an tor pain.						
	2.1.25(.)(2)							
	3.1-35(g)(2)							

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155605	B. WING			05/19/2	011
	PROVIDER OR SUPPLIER	HABILITATION CENTER		1959 E (DDRESS, CITY, STATE, ZIP CODE COLUMBUS ST ISVILLE, IN46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL					COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0329 SS=E	from unnecessary drug is any drug w (including duplicat duration; or withou without adequate it the presence of ac indicate the dose s discontinued; or al reasons above.						
	resident, the facilit residents who hav drugs are not give antipsychotic drug treat a specific cor documented in the residents who use gradual dose redu interventions, unle	rehensive assessment of a sy must ensure that re not used antipsychotic in these drugs unless therapy is necessary to redition as diagnosed and record; and record; and retipsychotic drugs receive ctions, and behavioral ress clinically contraindicated, continue these drugs.					
	Based on		F0.	329	 Residents # 33, 36, 43 an were not harmed. Pain care plans have been reviewed ar 		06/06/2011
		nd interview,			revised as indicated. See be for additional corrective		
		ty failed to			measures.2. All residents wi potential for or actual pain ha	ive	
		sidents were			the potential to be affected. plans of care related to pain been reviewed and revised a	have	
	being assessed prior to the administration of pain medication, failed				indicated.3. The policies related pain management		
					and medication administratio (see attachments E and F) w		
					reviewed and no changes we indicated. Licensed nursing	ere	
	to provid	e			were re-educated on those policies. The DON or her		
non-pharmacological				designee will review narcotic records, medication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/19/2011	
NAME OF PROVIDER OR SUPPLIER GRANDVIEW HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1959 E COLUMBUS ST MARTINSVILLE, IN46151			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) administration records and PRN Medication Flowsheets (which include assessments) daily on scheduled work days (see attachments G and H) for one month then twice weekly for one month, then weekly for two months, then monthly thereafter to ensure continued compliance. Pain care plans will		(X5) COMPLETION DATE
	interventions and failed to assess the effectiveness of the pain medications for 4 of 8 residents						
					be reviewed by the DON or designee monthly for three		
		l for pain		months then quarterly thereafter (see attachment I).4. The		eafter	
	manager				findings of these audits will b reviewed during the facility's	s	
	sample o				quarterly Quality Assurance meetings and the plan of a	ction	
	(Residen	•			adjusted accordingly.5. Th above corrective measures completed on or before Jur	will be	
	# 50, # 33, # 36).				2011.		
	Findings	included:					
	A policy, dated 8/2010, and received						
	on 5/18/	11 at 3:15					
	p.m., fro	m the Director					
	of Clinic	al Operations,					
	titled "M	ledication					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155605	A. BUII		00		05/19/2		
			B. WIN		DDRESS, CITY, STATE,	ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER				COLUMBUS ST	ZII CODE			
GRANDV	IEW HEALTH & RE	EHABILITATION CENTER		1	SVILLE, IN46151				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN	OF CORRECTION		(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	O THE APPROPRIAT	E	COMPLETION DATE	
IAG		tration Policy		IAG	<i></i>			DATE	
	and Proce	•							
	indicated	"Purpose:							
	To admin	nister							
	medication	ons according							
	to the gui	idelines set							
	forth by t	the State and							
	Federal								
	regulation	ns23.							
	Medication	on							
	administr	ration will be							
	recorded	on the MAR							
	[Medicat	ion							
	Administ	tration							
	Record]	or TAR							
	[Treatme	nt							
	Administ	tration							
	Record] a	after given"							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	DHOM11	Facility I	D: 000400	If continuation sh	eet Pa	ge 37 of 57	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		A. BUI	LDING	NSTRUCTION 00	СО	ATE SURVEY MPLETED 9/2011	
	PROVIDER OR SUPPLIER		B. WIN	1959 E	DDRESS, CITY, STATE, ZIP COE COLUMBUS ST NSVILLE, IN46151		0,2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	A policy,	received					
	from the	Director of					
	Nursing ((DON) on					
	5/17/11 a	it 11:30 a.m.,					
	dated 5/2	011, titled					
	"Pain Ma	ınagement					
	Procedur	e," indicated					
	"Procedu	re:5.					
	Documer	ntation of					
	administ	ration of the					
	ordered r	nedication					
	will be in	nitialed on the					
	front of t	he MAR6.					
	With the						
	administi	ration of PRN					
	[as neede	ed] pain					
	medication	on, additional					
	informati	ion including,					
	but not li	mited to					

000400

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605		(X2) MULTIPLE (A. BUILDING B. WING	OONSTRUCTION OO	COM	TE SURVEY IPLETED 0/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET 1959	FADDRESS, CITY, STATE, ZIP CO E COLUMBUS ST FINSVILLE, IN46151	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	reasons f	or				
	administi	ration,				
	intervent	ions				
	attempted	d, and				
	effective	ness of pain				
	medication	on will be				
	documen	ted on the				
	back of the	he MAR or				
	on a PRN	N Medication				
	Flow she	et"				
	 1. The re	cord of				
	Resident	# 43 was				
	reviewed	on 5/18/11 at				
	1:15 p.m	•				
	Diagnose	es for				
	Resident	# 43				
	included,	but were not				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI	LETED	
		155605	B. WIN			05/19/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST		
GRANDV	/IEW HEALTH & RE	HABILITATION CENTER		MARTI	NSVILLE, IN46151		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	limited to),					
	neurofibr	omatosis,					
	the grow	th of tumors					
	along ner	ves) pelvic					
	mass, neu	uropathy and					
	major de	pressive					
	disorder.						
	Recapitul	lated					
	physician	n's orders for					
	4/2011 in	dicated the					
	resident o	could receive					
	Percocet	(a narcotic					
	pain med	ication)					
	5-325 mi	lligrams 1					
	tablet eve	ery 6 hours as					
	needed for	or pain. The					
	original	late of this					
	order was	s 11/12/10					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605			(X2) MULTIPLE C A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 9/2011
	PROVIDER OR SUPPLIEF	EHABILITATION CENTER	1959 E	ADDRESS, CITY, STATE, ZIP C COLUMBUS ST INSVILLE, IN46151	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	A care pl	an for				
	1	# 43, dated				
	4/18/11,	indicated a				
	problem	of "The				
	resident l	has the				
	potential	for pain in				
	the follow	wing areas:				
	general, 1	pelvic Due to:				
	Dx [diag	nosis]:				
	Neurofib	romatosis,				
	Large Pe	lvic tumor,				
	chronic p	oain,				
	Neuropat	thy." A goal				
	was the r	resident would				
	have a pa	ain less than 5				
	on a scal	e from 0 - 10.				
	Intervent	ions included,				
	but were	not limited				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/19/2	LETED	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	B. WIN	STREET A 1959 E	ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST NSVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	to, "asses	ss pain on a					
	scale of 0) –					
	10Attei	mpt other					
	intervent	ions such as:					
	massage,						
	reposition	ning,					
	Administ	er pain					
	medication	ons as ordered					
	and moni	itor					
	efficacy	"					
	 Review o	of a PRN					
	Medicati	on Flow					
	Sheets in	dicated					
	columns	to be filled					
	out for da	ate, time,					
	reason, p	ain severity,					
	attempted	d alternative					
	intervent	ions,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 05/19/2	LETED	
	PROVIDER OR SUPPLIEI	EHABILITATION CENTER		1959 E	DDRESS, CITY, STATE, ZIP CODE COLUMBUS ST NSVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	medicati	on, initials					
	and effect	ctiveness each					
	time a PI	RN pain					
	medicati	on was given.					
	Review of	of Controlled					
	Drug Re	cord sign out					
	sheets in	dicated					
	Resident	#43 received					
	1 Percoc	et 96 times in					
	April, 20	11.					
	A review	of Resident					
	# 43's PF	RN					
	Medicati	on Flow					
	Sheets in	dicated only					
	38 entrie	s regarding					
	assessme	ent of his pain					
	and effect	ctiveness of					

000400

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE COMPL	ETED	
NAME OF I	DROLLIDED OD GUIDDI HED		B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
	PROVIDER OR SUPPLIER	HABILITATION CENTER		1	COLUMBUS ST NSVILLE, IN46151		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	· 		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	the admir	nistered pain					
	medication	on, out of the					
	96 times	it was given					
	in April.						
	A review	of the MAR					
	for Resid	lent # 43					
	indicated	only 20					
	entries of	f Percocet					
	during A	pril, 2011, out					
	of the 96	times it was					
	given.						
	During a	n interview					
	with the	Regional					
	Nurse Co	onsultant on					
	5/19/11 a	ıt 4:15 p.m.,					
	she indicate	ated the					
	resident's	s pain is					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE COMP		
		155605	B. WIN	G		05/19/2	2011
NAME OF I	PROVIDER OR SUPPLIER	3			DDRESS, CITY, STATE, ZIP CODE		
GRAND\	/IEW HEALTH & RE	EHABILITATION CENTER			NSVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	supposed	l to be					
	assessed	every time a					
	PRN pair	n medication					
	is admini	istered, and					
	the inform	mation is					
	supposed	I to be put on					
	the PRN	Medication					
	Flow She	eet, along					
	with the	follow up					
	assessme	ent regarding					
	the effect	tiveness of the					
	drug. Sh	e indicated					
	they had	been auditing					
	this proce	ess but had					
	only been	n checking the					
	MAR for	times of					
	administi	ration, not the					
	Controlle	ed Drug					
	Record.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605		(X2) MULTIPLE (A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 0/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREE* 1959	TADDRESS, CITY, STATE, ZIP (E COLUMBUS ST FINSVILLE, IN46151	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	2. The re	ecord of				
	Resident	# 50 was				
	reviewed	on 5/16/11 at				
	9:30 a.m.					
	Diagnose	es for				
	Resident	# 50				
	included,	, but were not				
	limited to	o, pressure				
	sores, en	d stage renal				
	disease, s	stroke, cancer,				
	depression	on and				
	dementia	.				
	A recapit	rulated				
	physiciar	n's order for				
	March, 2	011, with an				
	original o	date of				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		(X2) M A. BUI B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/19/20	ETED
	PROVIDER OR SUPPLIER	HABILITATION CENTER	B. WIN	1959 E	ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST NSVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	2/25/10,	indicated the					
	resident o	could receive					
	Hydroco-	-APAP (a					
	narcotic 1	pain					
	medication	on) 7.5-500					
	milligran	ns (mg) every					
	4 hours a	s needed for					
	pain.						
	Review of	of Controlled					
	Drug Red	cord sign out					
	sheets in	dicated					
	between	3/1/11 and					
	3/11/11	Resident # 50					
	received						
	Hydroco-	-APAP					
	7.5-500 r	ng. 21 times.					
	A review	of a PRN					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		A. BUI	LDING	NSTRUCTION 00		3) DATE SURVEY COMPLETED 05/19/2011	
	PROVIDER OR SUPPLIER		B. WIN	1959 E	DDRESS, CITY, STATE, ZIP COE COLUMBUS ST NSVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Pain Mar	nagement					
	Flow She	eet indicated					
	only 1 en	try regarding					
	assessme	ent of her pain					
	and effec	tiveness of					
	the admin	nistered pain					
	medication	on, out of the					
	21 times	it was given					
	between	3/1/11 and					
	3/11/11.						
	Review o	of the MAR					
	for Marc	h, 2011, for					
	Resident	# 50					
	indicated	only 1 entry					
		droco-APAP					
	7.5-500 r						
	between	3/1/11 and					
	3/11/11.						

000400

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE COMP	E SURVEY LETED
	155605		B. WIN	G		05/19/	2011
NAME OF I	PROVIDER OR SUPPLIER	1		1	DDRESS, CITY, STATE, ZIP CODE		
GRAND\	/IEW HEALTH & RE	EHABILITATION CENTER			NSVILLE, IN46151		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	` ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	PRIATE	DATE
	During a	n interview					
	with the	Regional					
	Nurse Co	onsultant on					
	5/19/11 a	ıt 4:15 p.m.,					
	she indic	ated the					
	resident's	s pain is					
	supposed	l to be					
	assessed	every time a					
	PRN pair	n medication					
	is admini	stered, and					
	the inform	mation is					
	supposed	to be put on					
	the PRN	Medication					
	Flow She	eet, along					
	with the	follow up					
	assessme	nt regarding					
	the effect	tiveness of the					
	drug. Sh	e indicated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPI 05/19/2	LETED	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1959 E COLUMBUS ST MARTINSVILLE, IN46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	they had	been auditing					
	this proc	ess but had					
	only been	n checking the					
	MAR for	times of					
	administ	ration, not the					
	Controlle	ed Drug					
	Diagnoses include CHF, anxiety, and stones, neuropath artery disease, os emphysema.	de but are not limited to, agina (chest pain), gall by (nerve pain) coronary					
	months of April and Resident # 33 has Hydrocodone-All by mouth every a for pain. During review of Control Record, PRN pain medical month of April, 6	and May, indicated that d an order for PAP 10-500 mg, 1 tablet 8 hours PRN (as needed) If the facility's Narcotic Resident # 33 received ation every day in the except April 4th, 2011. A					
	PRN pain medic month of April, e	ation every day in the					

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		155605	B. WING 05/19/2011				
NAME OF F				_	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF F	PROVIDER OR SUPPLIER			1959 E	COLUMBUS ST		
		HABILITATION CENTER			NSVILLE, IN46151		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
IAG		LSC IDENTIFYING INFORMATION)	-	IAG	DEFICIENCE TY	DATE	
	· -	w sheet" for April,					
		nt # 33 received an					
	_	ain levels, need of					
	medication,alterr						
	^ ~	methods, and efficacy on					
		tes: April, 13th, 15th,					
	' '	24th, 26th, 27th, 28th,					
	l '	The record indicated 18					
	days of PRN pair	n medication was					
	administered wit	hout prior assessment of					
	pain.						
	During review of	f the facility's Narcotic					
	Control Record,	Resident # 33 received					
	the PRN pain me	edication each day, from					
	May 1st to May	17th. A review of					
	Resident # 33's "	prn pain management					
	flow sheet" for M	May, indicated Resident #					
	33 received an a	ssessment of pain level,					
		on, alternative and non					
		methods, and efficacy on					
	-	tes: May, 2nd, 3rd, 5th,					
		h, 15th, 16th and 17th,					
		rd indicated 7 days of					
		ation was administered					
	without prior ass						
	"Turout prior ass	ossinone of pani.					
	During an intervi	iew with the DON on					
	During an interview with the DON on 5/19/11 at 2:00 p.m., further information was requested in regards to						
		e DON indicated there					
		formation in regards to					
	assessments.						
			- 1				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605		A. BUILDING	00	ì	E SURVEY PLETED /2011		
	PROVIDER OR SUPPLIER		B. WING GS/19/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1959 E COLUMBUS ST MARTINSVILLE, IN46151				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION	
TAG		r Resident # 36 was 3/11 at 1:00 p.m.	IAU	BEIGER		DATE	
	coronary artery osteoporosis, My	le but are not limited to, lisease, chronic pain, rasthenia Gravis, angina stipation, and depressive					
	months of April a Resident # 36 ha Hydrocodone-Al	PAP 7.5-500 mg, liquid 10 ml by mouth ever 6					
	Control Record, PRN pain medica 20th and 21st, 20 Resident # 36's " flow sheet" for A 36 received an a need of medicati pharmacological the following dat The record indica	prn pain management pril, indicated Resident # ssessment of pain level, on, alternative and non methods, and efficacy on tes: April 20th and 21st. ated 2 days of PRN pain administered without					
	Control Record, PRN pain medical	The facility's Narcotic Resident # 36 received ation on May 2nd, 7th, 011. A review of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDING COMPLET				
155605		155605	B. WING 05/19/2011				
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					COLUMBUS ST		
GRANDV	/IEW HEALTH & RE	HABILITATION CENTER		MARTIN	NSVILLE, IN46151		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF T	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	· ·	prn pain management					
		May, indicated Resident #					
		ssessment of pain level,					
		on, alternative and non					
		methods, and efficacy.					
	The document w	as blank.					
	Duning an interest	ion with the DON are					
	_	iew with the DON on					
	•	.m., further information					
	was requested in						
		alternatives. The DON					
		as no other information					
	available.						
	3.1-48(a)						
	` /						
	3.1-48(a)(3)						
F0514	,	naintain clinical records on					
SS=D	each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily						
		stematically organized.					
	The elimination is	must contain sufficient					
		must contain sufficient ntify the resident; a record of					
		essments; the plan of care					
	and services provi	ded; the results of any					
		ening conducted by the					
	State; and progres			514	4 B : 1 4 # 65		06/06/2011
		review and interview, the	F0514	514	 Residents # 33 and 36 we not harmed. See below for 	00/00/201	06/06/2011
	<u>-</u>	ensure residents' records			additional corrective measures.2. All residents with potential for or actual pain have the potential to		
	-	ete documentation for 2					
	of 8 residents rev	viewed for pain in a					
					be affected. See below for		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL			
		155605	A. BUI B. WIN	LDING		05/19/20	011	
			р. үүл		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIEF	(1959 E	COLUMBUS ST			
		EHABILITATION CENTER		MARTIN	NSVILLE, IN46151			
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
IAG	1		+	IAU	additional corrective measur	Ac 3	DATE	
		esidents # 33, # 36).			The policies related to pain management and medication			
	1. The record for	r Resident # 33 was			administration (see attachme			
	reviewed on 5/13	8/11 at 1:30 p.m.			E and F) were reviewed and			
					changes were indicated.			
	Diagnoses include	de but are not limited to,			Licensed nursing staff were re-educated on those policie	_		
	CHF, anxiety, ar	ngina (chest pain), gall			The DON or her designee w			
	stones, neuropat	hy (nerve pain) coronary			review narcotic records,			
	artery disease, or	steoporosis, and			medication administration re			
	I EHIDHVSEHIA I I				and PRN Medication Flowsh (which include assessments			
					daily on scheduled work day	' I		
	A recapitulated physicians order for the months of April and May, indicated that Resident # 33 had an order for				(see attachment G) for one r			
					then twice weekly for one mo			
					then weekly thereafter to en			
	Hydrocodone-A	PAP 10-500 mg, 1 tablet			continued compliance.4. Th findings of these audits will be			
	by mouth every	8 hours PRN (as needed)		reviewed during the facility's				
	for pain.				quarterly Quality Assurance			
					meetings and the plan of act			
	During review o	f the facility's Narcotic			adjusted accordingly.5. The above corrective measures v			
	Control Record,	Resident # 33 received			completed on or before June			
	PRN pain medic	ation every day in the			2011.	,		
	_	except April 4th, 2011. A						
	review of Reside	ent # 33's "prn pain						
	management flow sheet" for April,							
	1	ent # 33 received an						
	1	ain levels, need of						
	medication,alter							
	•	methods, and efficacy on						
	_	tes: April, 13th, 15th,						
	19th, 21st, 23rd, 24th, 26th, 27th, 28th,							
		The records reviewed						
	· ·	naining 18 days, no						
		ent documentation was						
	available.							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 1/2011		
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1959 E COLUMBUS ST MARTINSVILLE, IN46151				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE	
	Control Record, the PRN pain me May 1st to May Resident # 33's "flow sheet" for M 33 received an an eed of medicati pharmacological the following day 6th, 7th, 8th, 10t 2011. The recorremaining 7 days documentation where the following an intervisive for the following days documentation where the following days documentation where for the following an intervisive for the following days documentation. Further documentation. The following documentation. The following documentation further documentation for the following documentation. Diagnoses include coronary artery costeoporosis, My (chest pain), condisorder. A recapitulated pain for the following days are documentation.	iew with the DON on o.m. further information regards to any further. The DON indicated no tation was available. Resident # 36 was 8/11 at 1:00 p.m. de but are not limited to, disease, chronic pain, wasthenia Gravis, angina stipation, and depressive ohysicians order for the and May, indicated that					

000400

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155605		(X2) MULTIPLE CC A. BUILDING B. WING	00	ľ	e survey pleted /2011	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	1959 E	ADDRESS, CITY, STATE, ZIP C COLUMBUS ST NSVILLE, IN46151	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	1 -	PAP 7.5-500 mg, liquid 10 ml by mouth ever 6 eeded) for pain.				
	Control Record, PRN pain medica 20th and 21st, 20 Resident # 36's " flow sheet" for A 36 received an aneed of medication pharmacological the following dat The records revier remaining 2 days documentation where the pharmacological the following dat The records revier remaining 2 days documentation where the pharmacological the following dat The records revier remaining 2 days documentation where the pharmacological the following dat The records review of Control Record, PRN pain medical 11th and 12th, 20 Resident # 36's " flow sheet" for M 36 received no aneed of medication and the properties of the	prn pain management pril, indicated Resident # ssessment of pain level, on, alternative and non methods, and efficacy on res: April 20th and 21st. rewed indicated the s, no further assessment ras available. The facility's Narcotic Resident # 36 received ration on May 2nd, 7th, oll. A review of prn pain management May, indicated Resident # ssessment of pain level, on, alternative and non methods, and efficacy.				
	5/19/11 at 2:00 p was requested in documentation.	iew with the DON on .m. further information regards to any further The DON indicated no tation was available.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	155605	A. BUILDING	00	COMPLETED 05/19/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF P	PROVIDER OR SUPPLIER		l l	COLUMBUS ST	
		EHABILITATION CENTER	MARTI	NSVILLE, IN46151	
				PROVIDER'S PLAN OF CORRECTION	
				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	ATE (X5) COMPLETION DATE